Massachusetts Department of Public Health
Bureau of
Substance Abuse Services

This is a legal document, please do not copy

Instructions:

A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH PROGRAM
(not applicable to satellites) Please carefully read the regulations pertaining to the service you wish to license before applying for licensure.

FIRST TIME APPLICANTS ONLY:
You are advised to consult with your B.S.A.S. Regional Manager if you have not already done so. Your Regional Manager may consider a preliminary review of the program site and services. For assistance call your Regional Manager at the designated Public Health Office listed below:

Western, MA	(413) 586-7525	Northeast, MA	(978) 851-7261	Greater Boston, MA	(617) 541-2860
Central, MA	(508) 792-7880 ext.339	Metro West	(781) 828-7700	Southeastern, MA	(781) 828-7700 (Canton Office)
BSAS Main Office	(617) 624-5155				

FIRST TIME NARCOTIC TREATMENT PROGRAM APPLICANTS ONLY:
You must complete the Community Site Process identified in 105 CMR 162.500 A (2) prior To submitting this application. Please submit evidence of completion of the Community Siting Process to the Licensing Unit. Following this, you may submit your application for Licensure.

RENEWALS ONLY:
Completed applications must be returned to the Bureau of Substance Abuse Services no later than the date detailed in the ***Renewal License Package***. If you are **adding** or **deleting** a specialized service, please submit a brief cover letter that explains the change(s).

APPLICATION FEE:
$10.00 Residential Recovery Homes
$0.00 Therapeutic Communities, Family Shelters and Transitional Support Services
$25.00 ALL OTHERS

SEE FOLLOWING PAGE FOR MAILING INSTRUCTIONS

Mailing Instructions

Effective August I, 2002 please complete application and send along with required documents to the assigned (per enclosed letter) Licensing Inspector. Below you will find a list of all Licensing Inspectors with their appropriate mailing address.

Make **check** payable to: D.P.H./Bureau of Substance Abuse Services

Please make **copies** of pages 3 & 4 only of the application and return along with **check** to:

Gerry Romano
D.P.H./Bureau of Substance Abuse Services
250 Washington Street 3rd floor
Boston, MA 02108

Judi Robbins
Metro West Regional Office
5 Randolph Street
Canton, MA 02021
(781) 828-7909
TTY: 781-828-7277

Ruth Karmelin-Bice
Metro West Regional Office
5 Randolph Street
Canton, MA 02021
(781) 828-7031
TTY: 781-828-7277

Erica Piedade
Central MA Regional Office
refer & mail application to:
Western MA Regional Office
23 Service Center Road
Northampton, MA 01060

Ben Sullivan
Gr. Boston Public Health Office
10 Malcolm X Blvd.
Roxbury, MA 02119
(617) 541-8306
TTY: 617-541-8314

Erica Piedade
Western MA Regional Office
23 Service Center Road
Northampton, MA 01060
(413) 586-7525 ext.1182

Ann Canavan
Northeast Regional Hospital
Tewksbury Hospital
East Street, Tewksbury, MA 01876
(978) 851-7261 ext. 4023

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
BUREAU OF SUBSTANCE ABUSE SERVICES
Request for License Application and Renewal Form

1. **Program/Service Name**: _____ Tel. #: _____

Address: _____ Fax #: _____
(Street) (Town) (State) (Zip) TTY#: _____
E-Mail:_____

Mailing Address: _____

2. **Corporate Name**: _____ Tel#: _____
According to Articles of Incorporation
Fax# _____
TTY#:_____
E-Mail:_____

Address: _____
(Street) (Town) (State) (Zip)

Mailing Address:_____

3. **Parent Company Name**: _____ Tel #: _____
(if applicable)
Fax#:_____

4. Type of Organization **Public**: ☐ **Private:** ☐ Non-Profit ***If Private*:** ☐ Partnership
☐ For-Profit ☐ Proprietorship
B.S.A.S. Funded ☐ Yes ☐ No ☐ Corporation

Date of Incorporation: _____ National Facility Registry (NFR) Number :_____

Federal Employer I.D. No. (FEIN):_____

5. **Service Provided**

ACUTE TREATMENT SERVICES (Level A,B): ***Number of Beds*** _____ ***Use of Methadone?*** ☐***Yes*** ☐***No***

☐Inpatient Detoxification
☐Short Term Intensive Inpatient Treatment
☐*Pregnant Woman Specialization*
☐*Section 35*
☐*Dual Diagnosis Specialization*
☐*Youth*

RESIDENTIAL SERVICES: ***Number of Beds*** _____
☐*Pregnant/Postpartum Women Specialization*
☐*Women w/Children Specialization*

☐Transitional Support Services
☐Recovery Home
☐ Level A
☐ Level B
☐ Social Model
☐DUI
☐Therapeutic Community
☐Family Shelter
☐Youth Residential
☐Male
☐Female
☐Co-ed

AMBULATORY SERVICES:
☐*Pregnant Women Specialization*
☐Outpatient Counseling ☐Second Offender/Aftercare ☐Narcotic Treatment Program ☐Acupuncture Detox
☐Driver Alcohol Education ☐Intensive Outpatient ☐Outpatient Detox ☐Day Treatment

6. **Primary Responsible Official**: _____ Title: _____
(Name) (President of the Board)
Social Security Number: _____ Telephone: #: _____
Fax #:_____
E-Mail:_____
Address: _____
(Street) (Town) (State) (Zip)

7. **Secondary Responsible Official**:_____ Title: _____
(Name) (Program Administrator)
Social Security Number: _____ Telephone #: _____
Fax #:_____
E-Mail:_____
Address:_____
(Street) (Town) (State) (Zip)

8. **Satellite and/or Medication unit(s)** *(If more than 2 (two) sites, attach on separate page. For Mobile Vans, attach dispensing locations.)*

a. Name: _____
(Please indicate services provided also)

Address: _____ Telephone #: _____
TTY #: _____

b. Name:_____
(Please indicate services provided also)

Address: _____ Telephone #: _____
TTY #: _____

9. **Licensure/Approval Information (current numbers and dates where applicable):**

DPH/BSAS Treatment License: _____ Expiration Date: _____

Massachusetts Division of Food and Drugs
Controlled Substance Registration #: _____ Expiration Date: _____
Methadone/LAAM Registration #: _____ Expiration Date: _____

U.S. Drug Enforcement Agency Registration #: _____ Expiration Date: _____
Methadone/LAAM Registration #: _____ Expiration Date: _____
U.S. FDA/CSAT #: _____

10. **Certification**: We, the undersigned, under the pains and penalties of perjury, do hereby certify that all the material submitted to the Department by us on behalf of the applicant, respecting the subject matter of this application, is true to the best of our knowledge.

_____ _____
Signature of Primary Responsible Official Date

_____ _____
Signature of Secondary Responsible Official Date

THIS FORM MUST BE NOTARIZED IN THE SPACE PROVIDED BELOW:

Subscribed and sworn to before me this_____day of_____20_____.

My commission expires on_____20_____.

_____ (Seal)
Notary Public

PLEASE PROVIDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION

Program Design and Service Components:

☐1. Provide a brief narrative of Acute Treatment Services, Residential Services or Ambulatory Services. Include a description of each service type and any specialization checked off on page #2 of the application.

☐2. Describe the program's service elements including:

a. referral (how clients will access the program)
b. intake and admission (include requirements and necessary medical evaluations when applicable).
c. evaluation, assessment and diagnosis
d. treatment planning and reviews (breathalyzer and urine test use when applicable)
e. therapeutic process and counseling types
f. discharge, aftercare and follow-up

☐3. Provide staffing pattern for this specific service (see attached chart page10.)

☐4. Describe days and hours of operation.

Describe the Following Program Administration, Policies and Procedures

☐5. Client admission and exclusion criteria.

☐6. Name, address, and daytime phone number of each governing body member indicating community representation. If the governing board does not reflect community representation, submit the above noted information of the local advisory board.

☐7. Program evaluation plan including measurable goals and objectives and progress being made in reaching them.

☐8. Current substance abuse service organizational chart illustrating lines of authority, responsibility/ communication and staff assignment (include staff names and positions). If applicable, include an agency organization chart indicating where the substance abuse service fits into the agency structure.

☐9. If operating under a currently licensed hospital or mental health clinic, a copy of its license.

☐10. Current fire inspection certificate from local fire department.

☐11. Current building inspection certificate from state or local building inspector. All Residential and inpatient services need a current Health Certificate, as required by local board of health.

☐12. Evidence of compliance with the American with Disabilities Act (i.e. current Bureau Self-Evaluation Plan or DPH checklist).

☐13. Current professional and general liability insurance.

☐14. Agency's Tobacco-Free Policy.

☐15. Copy of most recent <u>annual audit</u> outcome letter and operating budget w/actual YTD amounts.

☐16. Biennial letters of affiliation for emergency and inpatient medical and psychiatric care.

☐17. Documentation of CPR-certified staff on site during hours of operation.

☐18. Written emergency evacuation procedures including staff member(s)' responsibilities.

☐19. Documentation of emergency evacuation drills stating date and time of drill, number of clients and staff conducting the drill which have occurred periodically within the last year and according to governing regulation.

☐20. ***Inpatient Detox Programs*** *ONLY* must provide a copy of the following:

- Drug Enforcement Agency (DEA) Certificate
- Massachusetts Division of Food and Drugs (MDFD) Certificate

☐21**.** ***Inpatient Detox Programs*** *using* ***Methadone*** must provide a copy of the above as well as the following:

- Federal Drug Administration (FDA) Approval Letter
- DEA Certificate for Methadone
- MDFD Certificate for Methadone

All programs must formulate plans and procedures to address specific situations and needs of clients affected by HIV/AIDS, TB, STD and HEP C

☐22. Provide program policy for admission of persons who have TB, STD and/or HIV/AIDS-related diagnoses.

☐23. Provide program policy on TB, STD and HIV testing for clients currently in treatment. Describe program procedures for pre- and post-test counseling. Specify where clients may be HIV tested.

☐24. Provide program policy regarding confidentiality about a client's TB, STD and HIV/AIDS diagnoses. Identify those staff persons having an "absolute need to know" regarding this information. Indicate how HIV status is maintained confidentially in client records.

☐25. Describe how the program provides clients and their families with information and counseling on STD, TB and HIV transmission, signs and symptoms and prevention/risk reduction. Describe how client education is documented in client records.

☐26. Describe staff orientation and ongoing training on HIV/AIDS/TB/STD/HEP C.

Client Records

☐27. New agencies submit sample client record that include following items. Renewals submit the following bulleted items and (29-31).

Copies of written form(s) used in authorizing the release of client information regarding:

- general information
- HIV/AIDS status
- STD status
- TB status
- HEP C

☐28. Provide client rules and responsibilities, client rights, formal grievance procedures, and discharge policies.

☐29. Provide the written fee schedule and policy statement distributed to clients.

☐30. Provide written protocols describing client record-keeping procedures.

☐31. Specify which staff members are authorized to <u>make entries</u> and which are to <u>have access</u> to records.

Staffing, Training & Supervision

☐32. Provide training plan for staff orientation.

☐33. Provide plan and schedule for regular in-service staff training for all addictions treatment staff and medical staff. Include in-service schedule with topics and presenters for the **next 12 months**.

☐34. Submit schedule of staff clinical supervision.

☐35. Submit current resume(s) of Clinician I responsible for full time clinical operation of the substance abuse service (*except family shelter and residential programs*).

☐36. Submit resume of qualified administrator responsible for day to day operations.

☐37. Attach current performance evaluation tool.

☐38. Staffing pattern:

a) For each position on page applicable to your program, fill in the requested information on chart attached to this application. State if position is currently vacant.

b) Provide job description with salary ranges for each position.

c) Submit your program's current weekly staffing schedule (including names).

INFORMATION MUST BE PROVIDED FOR EACH SPECIFIC PROGRAM TYPE LISTED:

•Narcotic Treatment •Driver Alcohol Education •Second Offender Aftercare Service

NARCOTIC TREATMENT PROGRAMS

☐39. Indicate what rules and responsibilities a client must observe in order to remain in your program. Provide the program's policy regarding non-compliance and attendance at counseling sessions.

☐40. Procedures for voluntary, involuntary and emergency termination distributed to clients.

☐41. Describe the protocol for establishing and adjusting the narcotic medication level. Specify the program's philosophy on the level of narcotic medication (typical mg.) and the magnitude of reductions.

☐42. Provide the written policy statement regarding take home of methadone distributed to clients.

☐43. Provide a copy of the following:

- Federal Drug Administration (FDA) approval letter
- Drug Enforcement Agency (DEA) certificate for Methadone
- Massachusetts Division of Food and Drugs (MDFD) certificate for Methadone

☐44. Describe how client status is recorded during daily medication and made accessible to clinical staff.

☐45. Document the need for narcotic treatment services in your community. Describe the geographical area you expect to serve and provide data specific to the need for narcotic treatment services in that area.

☐46. *MOBILE SITES ONLY*: Describe your program's procedure for sharing client information between staff providing daily narcotic medication and staff providing counseling and medical care.

DRIVER ALCOHOL EDUCATION PROGRAM

☐47. Provide an outline of the curriculum used for Driver Alcohol Education.

☐48. Indicate instrument used to conduct DAE client assessments.

☐49. Describe specialized programming for under 21 offenders or any other special populations, as applicable.

SECOND OFFENDER AFTERCARE SERVICE

☐50. Written commitment to provide the Office of Probation with required documentation.

☐51. Explain each phase of treatment specific to your program.

RESIDENTIAL TREATMENT SERVICES

☐52. Submit a copy of safe storage of medication guidelines and policies.

☐53. Facility must possess a local Board of Health Certificate.

FAMILY SHELTER

☐54. Necessary certificates/permits include:

- ☐ Occupancy permit which includes number of infant beds
- ☐ Certificate of Compliance by DPH/Child Lead Poisoning Project

☐55. Emergency exiting policies with provision for infants and children on the premises

☐56. Submit a list of all contracted outpatient providers and which service(s) is being provided by each.

☐57. Submit policy and procedures for the provision of adult supervision of children during treatment, and for staff supervision of children when parents are unable to supervise children.

☐58. Document ability to provide case management that includes assistance in accessing entitlement programs.

☐59. Document ability to provide job training and job placements assistance.

CONT'D FAMILY SHELTERS

☐60. Submit a floor plan that includes numbers of adult, child and infant beds/cribs per room.

☐61. In lieu of questions 37 and 38 under "Staffing, Training and Supervision" (pg.5), submit resumes for the Program Director and Child Service Coordinator.

☐62. In addition to your staffing schedule, called for in question 40 under "Staffing, Training and Supervision" (pg.5), please include a back-up staffing plan.

TRANSITIONAL SUPPORT SERVICES

☐63. Document ability to provide case management, including coordination of appropriate program affiliations and linkages to meet client needs.

☐64. Document ability to make referral arrangements for physical examination, necessary test(s) and/or consultation by qualified professionals according to client needs.

☐65. Document ability to provide or arrange transportation to aftercare interviews, placements and resource visits.

☐66. Document current linkage agreements with licensed substance abuse treatment facilities and licensed mental health facilities.

PROGRAMS PROVIDING SPECIALIZED SERVICES FOR *PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS/CHILDREN*, MUST COMPLETE THE FOLLOWING APPROVAL REQUIREMENTS

ALL MODALITIES SERVING PREGNANT AND/OR POSTPARTUM WOMEN MUST RESPOND TO ITEMS 68-74 . ADDITIONALLY:

- **Detox Services Complete 75-81**
- **Residential Complete 82-85**
- **Outpatient Complete 86-91**

Program Facility/Environment

☐67. Submit emergency evacuation policies that include provisions for infants and children on the premises.

Administrative

☐68. Document designated hospital for emergency obstetrical and medical services with current affiliation agreement.

☐69. Affirm your affiliation with providers of the following services, indicate your contact person, address and phone number.

- prenatal, pediatric and primary health care providers
- WIC
- early intervention programs
- visiting nurse agency
- family planning/reproductive health programs
- Department of Transitional Assistance
- Narcotic Treatment and Other DPH approved modalities
- victims of violence program
- narcotic treatment programs
- Healthy Start
- mental health services
- violence prevention programs
- Department of Social Services

☐70. Submit annual training plans regarding issues specific to pregnant women with substance abuse issues, including infant CPR training/certification, HIV/STD/TB/HEP C issues specific to pregnant women, HIV/STD/TB/HEP C testing, and HIV/STD/TB/HEP C counseling and treatment.

Services

☐71. Submit policy on admission of pregnant women in all trimesters and post-partum women with provisions for medical complications.
☐72. Document ability to provide or arrange transportation to and from all medical, prenatal and social service appointments during length of stay.
☐73. Document ability to provide case management services that include assistance in accessing entitlement programs, specifically Medicaid, EAEDC and early intervention.
☐74. Document outreach process with community agencies.

SPECIALIZED DETOXIFICATION SERVICES FOR PREGNANT SUBSTANCE ABUSING WOMEN

Program Facility/Environment

- Facility must be licensed to provide Inpatient Substance Abuse Detoxification Treatment Services.

☐75. Submit a floor plan that illustrates the facility layout which insures privacy and promotes dignity for women.

Administration/Staffing

☐76. One FTE RN with OB/GYN experience per four (4) clients and .25 FTE RN with OB/GYN experience for each additional resident. If position is currently vacant, please submit interim plan for coverage. If position becomes vacant tin the future, the agency must submit a written interim plan for coverage approved by the Bureau.

Services

☐77. Submit clinically appropriate medical protocols for the safe detoxification of pregnant women in all trimesters.
☐78. Submit procedures for pre-admission screening and referral for women with medical needs which are beyond the capability of the program to accommodate and/or when beds are not available at the facility.
☐79. Submit procedure for insuring that a prenatal care appointment is made for every pregnant client admitted, unless the client already has a documented appointment with an obstetrician.
☐80. Document ability to access non-emergency prenatal care appointments for pregnant clients within 24 hours, when necessary.
☐81. Document case management services that include assistance in accessing entitlement programs, specifically Medicaid, AFDC, early intervention. Case management services are intended to facilitate a range of completed post-detoxification referrals.

SPECIALIZED RESIDENTIAL TREATMENT SERVICES FOR PREGNANT AND POSTPARTUM SUBSTANCE ABUSING WOMEN AND THEIR INFANTS

Program Facility/Environment

☐82. Submit occupancy permit which includes number of infant beds.

☐83. Facility must meet health and safety regulations including:

- Facility must be lead-free as indicated by a Certificate of Compliance by DPH/Child Lead Poisoning Project
- 25 square feet needed for each crib/bassinet
- Each infant requires a separated sleeping bed from the mother
- Submit program policies that include plan for exiting in an emergency that includes provision for infants and children on the premises
- All cribs meet federal safety requirements
- No pillows are used inside infant cribs

Administration

☐84. One FTE case manager per four per (4) pregnant/postpartum residents and .25 FTE case manager for each additional resident. A minimum of a bachelor's degree in psychology, counseling, social work, or a related discipline and substance abuse experience is preferred. If position is currently vacant, please submit interim plan for coverage. If position becomes vacant in the future, the agency must submit a written interim plan for coverage approved by the Bureau.

☐85. Submit policy and procedures for the provision of childcare during treatment.

SPECIALIZED INTENSIVE OUTPATIENT/DAY TREATMENT SERVICES FOR PREGNANT AND POSTPARTUM WOMEN

Administration

☐86. Submit a clearly defined process for verifying client pregnancy.

☐87. Submit program hours that accommodate women who may have other children (for example, school-age children).

☐88. For day treatment, submit service description that differentiates this program form other outpatient modalities.

☐89. Submit documented affiliations with providers of prenatal, postpartum and pediatric medical services.

Services

☐90. Submit treatment planning process for women 30 to 60 days postpartum.

☐91. Submit procedures for provision of access to childcare during treatment.

- Case management services must be provided and include assistance in accessing Medicaid through Presumptive Eligibility, EADAC, WIC and Early Intervention Programs for children birth to three years of age.

AGENCY STAFFING PATTERN

STAFF POSITION	NAME	SEX	RACE	YEARS OF EDUCATION OR PROFESSIONAL DEGREE STATUS	CERTIFICATE LICENSE REGISTRATION	YEARS OF SUBSTANCE ABUSE EXPERIENCE	YEARS OF CLINICAL SUPERVISORY EXPERIENCE	% OF FTE
EXECUTIVE DIRECTOR								
***PROGRAM DIRECTOR**								
***MEDICAL DIRECTOR**								
***BUSINESS MANAGER**								
CLINICAL SUPERVISOR/ CLINICIAN								
***NURSING SUPERVISOR**								
NURSE/RN								
NURSE/LPN								
NURSING ASSISTANT								
***COUNSELOR**								
COUNSELOR								
COUNSELOR								
OTHER								